

Promoting sexual safety through empowerment

**A review of sexual safety and the support of people's
sexuality in adult social care**

FEBRUARY 2020

Care Quality Commission

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The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

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- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

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Foreword

It is a basic human right for people to express their sexuality and to be empowered, supported and protected when using adult social care services. We want this report to encourage a conversation about sexual safety, sexuality and respectful relationships in adult social care.

We used our independent voice to initiate this review because people who use services and their families told us of their shocking experiences of sexual abuse in adult social care. Their message is that people who use services, wherever they receive them, must be protected from any similar abuse and suffering, and that a culture must be developed where all people, including staff, feel empowered to talk about sexuality and raise concerns around safety where necessary.

We were terribly saddened and moved by these experiences. By contrast, we have also heard some really positive examples where care staff and other stakeholders, such as advocacy groups and members of the public, work hard to promote independence and dignity for people. As part of holistic, person-centred care planning, they support adults of all ages to develop friendships and, if they wish, sexual relationships. They support people to feel comfortable to explore and express their sexuality. Rightly, they were keen that we talk about this support – both to prevent abuse, but also to make sure that people’s human rights are understood and protected. Adults who use care services have a right to explore their sexual identity and develop relationships, be that in a care home, a domiciliary care agency, or supported living.

We have therefore, in response to stakeholder feedback, explored both sexual safety and supporting sexuality in this report. We believe that, although these areas are different, they are interconnected, and need to be considered together when supporting and empowering people.

Sexual safety and supporting sexuality are complex areas, and we have not been able to look at all aspects of them. But we think that this report builds on our guidance on *Relationships and sexuality in adult social care services* by sharing what we know from our analysis, examples of abuse, as well as examples of good support, and what people have told us. The adult social care sector will also need to consider the new Liberty Protection Safeguards that are due to come in to effect in October 2020.

There are certain things that we have kept on hearing – from people who use services, their families, from care staff and providers and from those organisations that support them.

The first is that abuse in all its forms can never be accepted. We know from our own findings, and from feedback from others, that people who use adult social care services, including people with a learning disability, people living with dementia or people who communicate non-verbally, are potentially at a higher risk of abuse. As witnessed in some high-profile cases, a closed culture and environment, where the very worst practices can go on unchallenged, can cause very dire outcomes for people using services.

By contrast, an empowering culture, where staff feel they can share concerns without fear of reprisal; where people and families are encouraged to speak about their wants and needs

in a sensitive and unrushed way; and where managers and providers proactively enable conversations about sexuality to take place – these are the conditions that lead to people being empowered to stay safe and supported.

Talking about sexuality in adult social care should not be taboo. We have heard from some care providers and family members who say about those in their care – ‘they don’t want to talk about sex’. And that may be the case for some people. But being closed to talking about sexuality and consensual sex, as the most basic of human needs, can mean that people may not receive the best care or support. And it’s potentially increasing the risk of people carrying out sexually inappropriate actions – through a lack of awareness, vigilance, activity, or support and guidance. This can place themselves and others at risk of harm.

Sexual incidents happen in all types of adult social services, and are mostly carried out by people who use services. These incidents include sexual assault, sexual harassment and verbal abuse. We see examples of these incidents in this report, most of which come from notifications that providers sent to CQC. Many of them make for difficult reading.

These sexual incidents are not common. Sexual incidents made up around 3% of the total notifications of abuse or alleged abuse we received in our review period. But, from speaking to those who have been affected by sexual abuse, the impact and consequences can be life-changing. Their message to us is that more needs to be done to prevent sexual abuse happening.

By their nature, notifications tend to describe situations where things have gone wrong, and do not tend to reflect the huge amount of compassionate care and support given to around a million people in adult social care in England, and the important relationships that are built between people who provide care and those that receive it. Notifications do, however, tell us what the provider has done to escalate the issue and to provide support to people and mitigate the risk of it happening again.

We have found it more difficult to find examples of where people have been supported in expressing their sexuality and having their needs met – particularly for older people. There is a lack of confidence among care staff, managers and providers in giving this support. And there is a lack of advice and good practice – particularly for services that support people living with dementia. These are similar issues to those we raised in our report on sexual safety on mental health wards.

We share our learning in this report, and make recommendations for cross-system improvements, but we cannot provide all the answers. Our main aim is to encourage an open conversation across adult social care and the wider system, which leads to greater confidence and awareness of what works to keep people safe from sexual harm, and empowers them to express their sexuality to lead full lives determined and led by their own choices, needs and wants.

Kate Terroni

Chief Inspector of Adult Social Care

Deborah Ivanova

Deputy Chief Inspector,
Adult Social Care

Summary

This report looks at how people are kept safe from sexual incidents in social care services, and also how they are supported to express their sexuality. Although these areas are different, stakeholders told us that they are interconnected, and both need to be considered when supporting and empowering people.

It follows on from our report on *Sexual safety on mental health wards*, which concluded that more needed to be done to keep people safe.

It is clear from our discussions with people using services, staff, providers and their representatives that the first step to protecting and supporting people is having a culture of openness to talk about sexual safety and sexuality.

We want this report to encourage a conversation about sexual safety, sexuality and respectful relationships in adult social care, as people have every right to express themselves, to be treated with dignity and to be kept safe from harm.

Findings from our notifications analysis

Registered providers must notify us about certain changes, events and incidents that affect their service or the people who use it. When they notify us about these incidents, they are required to demonstrate that they have taken the right steps to protect people using their services, and to refer them to local authority safeguarding teams, the police and other agencies as appropriate. We support local authorities and the police by sharing information, where appropriate, from our regulatory activity, working closely with them when taking enforcement action, prosecuting providers and closing services in the most severe of instances.

In this report, we use information from the 'notifications' that CQC received from 1 March 2018 to 31 May 2018 where providers were notifying us about a sexual incident. These notifications included incidents that were observed by staff, as well as allegations of abuse, and, like all notifications, the effect on people varies considerably, from no or little impact to a very serious impact. We do not routinely collect information on the abuse, or alleged abuse, of people other than those using services, so abuse on staff, for example, does not form part of our notifications analysis.

We discuss potential issues with the quality of the notifications information later in this report, and urge readers to treat the notifications findings as suggestive rather than definitive. This is why we have used the notifications findings as part of our analysis, and supported them with findings from people who use services, providers and other stakeholders.

From the three-month period we reviewed, we identified and analysed 661 statutory notifications that described 899 sexual incidents or incidents of alleged sexual abuse that took place in adult social care services. These notifications were around 3% of the total notifications of abuse or alleged abuse we received in this period.

Almost half (48%) of the incidents reported in this period were categorised as sexual assault, defined as sexually touching another person without their consent. The second most common type of incident (11%) was exposure and nudity, and 8% were categorised as sexual harassment. There were 47 (5%) allegations of rape. CQC has followed up the alleged rapes with providers to ensure they have addressed incidents appropriately, including involving relevant agencies such as the police, safeguarding teams and the local authorities.

In the period of our review, most incidents were alleged to be carried out by people who use services (nearly 60% of the notifications), and the vast majority of people affected were also people using services. In 16% of cases, the alleged incidents were carried out by employed staff or visiting workers, and in 8% it was friends or relatives.

Sexual incidents were nearly four times more likely to be carried out by men (485) than women (126) during the period reviewed. And women were over three times more likely to be affected by sexual incidents than men. Forty-five per cent of all people affected were women aged 75 and over in our findings.

Of the 661 notifications, 46% were from a residential care home, 28% from a nursing home, 12% from a domiciliary care service, and 2.5% from other services, such as supported living, Shared Lives, and extra care housing. The rest of the notifications (11.5%) were from services that provide more than one type of care provision.

Nearly all the notifications had some information about what care providers did in response to the individual incidents. On the whole, providers spoke about how they had sensitively managed incidents. Managers and staff reported that they intervened and prevented or stopped any inappropriate sexualised behaviours as soon as they could and involved the relevant agencies, such as the police, in investigations.

Findings from our wider engagement

As part of this review, we spoke to people who use services and their families and carers, including those who have been involved in sexual safety incidents. We also spoke to care providers, charities and other stakeholders.

Stakeholders told us that sex is often seen as a 'taboo' subject. Staff, providers and families can be reluctant to raise issues. This can affect people's wellbeing, but also means that, where there is unacceptable or predatory behaviour, this can be overlooked or normalised. This reluctance can be due to uncertainty about the issue, a fear of getting things wrong, or a fear of enforcement or litigation as a result of reporting. This is understandable when there is a lack of guidance for providers.

Although we do not routinely collect data on incidents of staff experiencing sexual harm, care worker advocates told us that it does happen, and that staff can, and should, report these incidents to their managers where they should be recognised and dealt with.

Families and carers told us their loved ones are not always kept safe after an incident has happened. There were also concerns that people do not get access to the help and the support they need after these incidents occur, such as therapy or counselling.

The groups we talked to raised concerns about a lack of, or insufficient, learning and development for staff, as well as a lack of policies and recruitment guidance regarding sexual safety. They also told us of a lack of legal support, advocacy, and communications support for people who use services and their families.

We also heard about providers that have developed ideas and processes to support people and staff, which are highlighted throughout this report. This support not only serves to help people express their sexuality, but can also prevent incidents by intervening before they happen.

Learning from this review

Our learning from this review, which is examined in the body of the report, is:

- People are better protected when they are empowered to speak out about unwanted sexual behaviour and can speak openly about their sexuality
- Effective adult social care leaders develop a culture, an environment, care planning and processes that keep people and staff safe, and support people's sexuality and relationship needs
- People want to be able to form and maintain safe sexual relationships if they wish
- The impact of people's health conditions on sexual behaviour is not well understood
- Women, particularly older women, were disproportionately affected by sexual incidents in our findings
- There are some actions that providers in all care settings can carry out to help keep people in their service safe from sexual harm
- There are emerging concerns about the use of social media, mobile phones and the internet in sexual abuse
- Joint-working with other agencies, such as local authorities and the police, is vital to keep people safe

Summary recommendations (see detailed Our recommendations for action on page 43)

Our analysis and engagement has found that people are not always protected from sexual harm or supported to express their sexuality. We have been working closely with national bodies and other stakeholders to agree what needs to be done. These recommendations, which are based on the feedback we have received, require changes in different settings across adult social care, with the support of the whole local system.

A lack of awareness of good practice in sexual safety and sexuality can place people at risk of harm

1. We recommend that Skills for Care update their guidance on ‘Supporting personal relationships’ to incorporate the learning from this report by Spring 2020. This guidance for care managers and staff should be co-produced with a wide range of stakeholders. We recommend that this should be a practical guide to make sure staff know how to protect people using adult social care from sexual abuse and how to support them to develop and maintain relationships and express their sexuality.

A culture must be developed where people and staff feel empowered to talk about sexuality and raise concerns around safety

2. We recommend that providers and leaders across the adult social care sector develop a culture, environment and processes that support people’s sexuality, keep them and staff safe from sexual harm, and promote people’s human rights.

As the regulator, we have a strong role in making sure that people using services are protected and supported

3. The Care Quality Commission should continue to strengthen our processes to ensure that people’s human rights are protected and that they are kept safe from abuse in adult social care services, including sexual abuse, and empowered to make positive relationships, through improved monitoring, risk assessment and inspection.

Lived experiences

People who use services, their families and others who care for them – both informally and professionally – have been keen to tell us about their experiences of adult social care. Our conversations with them have been the driving force for this report from the very start. As partners in this work, they have helped us understand the impact of sexual safety incidents and the importance of good support. We are very grateful for their bravery and determination to make a difference.

The two experiences below are very different. The first shows leadership and care in adult social care at its best. It describes how managers and staff can support people to develop life-changing relationships and the positive impact it can have on those concerned.

The second is a distressing account of abuse of power. It tells of a woman who was harmed terribly by a care worker, and her son's ongoing feelings of devastation, guilt and betrayal. It ends in suggestions for learning, with the hope that something positive can come from the worst situations. The care worker does not represent the vast majority of hardworking, supportive staff, some of whom we have met and worked with in developing this report.

Language and terms used in this report

We are aware that the content of this report may at times be difficult to read because of the nature of the subject. We have done our best to be respectful and use appropriate language and have anonymised all examples or changed people's names.

We have also developed a [glossary](#) in the hope of being as clear as possible on what we mean by the terms used throughout this report. For example, when we talk about 'sexuality', we have kept the definition deliberately broad, to encompass a person's gender identity, sexual orientation, and sexual desires and experiences, including relationships.

Lizzie and Ian's experience

Lizzie and Ian live in a small care home for young adults with learning disabilities. Over time, they got very close and became boyfriend and girlfriend.

They wanted to develop their relationship further, including sexually, so asked for the support of the care home manager.

The manager sought advice from an organisation that educates people with learning disabilities about expressing sexuality and consent. Staff from the organisation came to have one-to-one talks with Lizzie and Ian. They also took the opportunity to talk to other residents and staff about relationships. Their advice focused on not being judgemental, while being respectful to others. Lizzie and Ian were supported to express their thoughts and feelings in ways they could understand and felt most comfortable.

Lizzie and Ian's parents were initially anxious and resistant about the relationship. Lizzie's father didn't want to visit the home when Ian was around, which was upsetting for them both. The manager's approach with the parents was to treat them sensitively and to gain their trust. He achieved this by getting advice, and also by showing that supporting their relationship is part of a wider health and care plan that seeks to enhance their independence and quality of life. Supporting Lizzie and Ian's parents to come to terms with the relationship was a breakthrough.

Lizzie and Ian were both given advice on safe sex and contraception and encouraged to talk about their feelings with their keyworkers and friends. When either Lizzie or Ian are away from the home, the other can get anxious, so staff reassure them and let them know when they will return.

They are also supported do the everyday things that couples can enjoy – cooking for each other, going shopping, going out for dinner and to the cinema. They like similar TV shows and look forward to going on holiday together. From meeting Lizzie and Ian, it is clear that their relationship is very important to them. You can see that they take great joy and strength from being together; from sharing a joke, to making plans – both in the short-term ('what will we have for dinner tonight?') to the longer term ('do we want to get married?').

Jane and Tom's experience

After an active and fulfilling life, Tom's mother Jane was diagnosed with Alzheimer's disease. As her mental health deteriorated, Tom felt it was in her best interests to move her into a care home that was close to friends and well regarded locally.

Jane was a strong and independent character and did not settle in easily, sometimes being resistant to help, particularly with personal care. Jane was then diagnosed with terminal cancer and was supported by staff with end of life care. As her illness increased she was mainly calm, but was still sometimes reluctant to accept care. Staff and family believed this was down to her strong character. Jane passed away soon after her diagnosis.

A few months after her mother passed away, Tom was contacted by police who told him that footage had been found, by chance, on a computer. The footage showed his mother being abused, including serious sexual assault. The care worker had worked on her own at night, visiting people in their rooms and abusing several residents, while her colleague slept. She had filmed the assaults on Jane and two other residents on her personal mobile phone. It is believed she shared the footage with her boyfriend.

Jane had passed away before the assaults on her became known and, due to her condition, had been unable to speak out about what was happening to her.

The care worker admitted that she had specifically targeted the most vulnerable because they would not be able to complain about the assaults. She had access to care plans and intimate details of their conditions. When interviewed and asked how Jane may have felt during the assaults, the care worker said "Scared". The care worker was criminally prosecuted, convicted and received a prison sentence.

Tom feels guilty that he couldn't keep his mother safe. He also feels the home did not protect his mother and failed Jane. He believes there is specific learning that would help keep all people using adult social care services safe:

- Vigilance – Jane showed no significant changes to her behaviour and was unable to voice her feelings. Staff need to be constantly vigilant around the people in their care, question and challenge what is going on, and not be automatically trusting of others.
- Lone workers – the provider's lone working policies and a lack of evidence of spot checks at night meant that the care worker could commit serious offences unchallenged.
- Gender and sexual assaults – sexual abuse is carried out by women as well as men.
- Transparency – communication and empathy between providers and families are key to providing safe care. A culture of openness gives staff and people using services and their families and carers confidence to speak out.

Tom and his family were devastated, not only by the loss of their mother, but also by the fact that she had been sexually abused in a care home that the family had trusted to provide safe end of life care for her. Jane passed away without anyone realising she had been sexually abused, and the care home failed to see the risk posed by their staff member. The family's distress was further compounded by the lack of any communication or support from the home after the abuse had been discovered. Tom hopes that learning will come from the horror that his mother experienced; that providers will take responsibility for ensuring their services develop a culture of openness to prevent something similar happening again.

Introduction

People using adult social care services should be supported to lead full lives determined and led by their own choices, needs and wants. This support should allow them to live with dignity and in safety and ensure their human rights are understood and protected. This includes respect for family and private life, and freedom of thought and expression.

A person-centred approach to care, which considers people's holistic needs, will include an understanding of a person's sexual identity and how they should be supported to appropriately express their sexuality in a way that supports and empowers them and protects them from harm.

People will experience full lives in care services that are run by leaders who make sure care plans and risk assessments are based around people's needs. They will inspire a culture of openness that informs, trains and supports staff. They will also encourage conversations between staff and with people who use services, their families and carers.

People, including staff, must be kept safe from sexual harm and abuse. Predatory behaviour is unacceptable, and people should not experience fear and helplessness because they have not felt able, or are not able, to talk about their sexual needs or experiences of sexual harm.

This is particularly important where people have a limited ability to protect themselves physically or emotionally, are unable to articulate their concerns and worries, or feel they are not listened to, as a group or as an individual. When people are not able to communicate verbally, particular care needs to be taken to spot signs of abuse by being aware of changes in behaviour and looking at what is behind the change.

People and staff must be supported to have a voice, for example through the effective use of independent advocacy and through clear processes for raising concerns, including whistleblowing.

Our notifications findings highlight that many people using adult social care, who were subject to sexual incidents, had some form of, or combination of, physical or learning disability, mental ill health or neurological condition, such as dementia.

Engagement with stakeholders and our own research in developing our *Relationships and sexuality in adult social care services*¹ guidance has highlighted the impact of neurological conditions on sexual behaviours. This does not account for all sexual safety incidents, but it is important to understand this when considering our findings.

Purpose of this report

This report aims to raise awareness of issues of sexual safety and sexuality in adult social care. It looks at how people using services are kept safe from sexual incidents, and how they are supported to express their sexuality.

It follows on from our report on *Sexual safety on mental health wards*,² which concluded that more needed to be done to keep people safe and to maintain their privacy and dignity

at a time that, for many, is the most vulnerable point in their lives. Following the development of this report, we recommended that there is a whole-system approach to improve the knowledge and skills of staff in supporting people's sexual safety.

It is clear from our discussions with people using services, staff, providers and their representatives that the first step to protecting and supporting people is having a culture of openness to talk about sexual safety and sexuality.

While we focus on sexual safety and supporting sexuality in this report, we fully acknowledge the importance of non-sexual relationships in adult social care. For example, people moving into, or between, care services can experience the loss of close contact with friends and family members, and therefore companionship becomes an important factor in people's quality of life.

The purpose of the report is not to investigate individual incidents, but to provide an overview of these incidents nationally. We want this report to encourage a conversation about sexual safety, sexuality and respectful relationships in adult social care. Whether people receive services in care homes or in their own homes, these settings are where people live, and they have every right to express themselves, to be treated with dignity and to be kept safe from harm.

How we carried out the work

Notifications analysis

We selected all statutory notifications that CQC received from 1 March 2018 to 31 May 2018 where providers had ticked a box to say they were notifying us about a sexual incident. These notifications included incidents that were observed by staff, as well as allegations of abuse.

On review, we found that some of these notifications were not actually about sexual incidents, or they were duplicates of other notifications in our selection, so we removed them from our analysis. This indicates that some providers had ticked the wrong box, or submitted multiple notifications about the same incident. It is therefore reasonable to assume that other notifications of sexual incidents are missing from our analysis because providers have ticked the wrong box. At this time, there is no efficient way of checking how many such notifications might have been omitted from this analysis.

CQC relies on the reporting organisations for the quality of the data. While most providers are precise in their reporting, we do occasionally receive poorly completed notifications.

Taking this into account, we urge readers to treat the findings presented in this report as suggestive rather than definitive.

Engagement, consultation and co-production

To supplement our analysis and help shape our learning and recommendations, we worked in partnership with people with who use services, their families, carers and representatives, as well as providers and other organisations at every stage of this report's development. This engagement included:

- Face-to-face workshops with people with learning disabilities, and Experts by Experience, who have used health and social care services and who support us with our inspections and other work.
- Co-production meetings with organisations that represent people who use services, care providers, voluntary groups and other stakeholders.
- Webinars with charities that have a key role in providing advice and promoting improvement in sexual safety.
- A data request from local Healthwatch and voluntary sector organisations.

We are very grateful to the many people and organisations that helped us develop this report.

Main findings

Findings from our notifications analysis

Background to notifications

Registered providers must notify us about certain changes, events and incidents that affect their service or the people who use it.

When providers notify us about these incidents, they are required to demonstrate that they have taken the right steps to protect people using their services, and to refer them to local authority safeguarding teams, the police and other agencies as appropriate.

CQC's responsibility is to make sure that providers have the right systems and processes in place to protect people from abuse and neglect. We do this through our inspection regime. We publish ratings and inspection reports, so that people who use services can understand if providers have effective systems to keep people safe. When necessary, we will hold providers to account, including through our enforcement action, to make sure they improve.

It is important to note that we do not carry out safeguarding investigations or enquiries, as that is the responsibility of the relevant local authority or the police. The police lead investigations where criminal offences are suspected, for example by preserving and gathering evidence as early as possible. We support local authorities and the police by sharing information, where appropriate, from our regulatory activity, working closely with them when taking enforcement action, prosecuting providers and closing services in the most severe of instances.

Notifications analysis in this report

In this report, we use information from the 'notifications' that CQC received from 1 March 2018 to 31 May 2018 where providers were notifying us about a sexual incident. These notifications included incidents that were observed by staff, as well as allegations of abuse, and, like all notifications, the effect on people varies considerably, from no or little impact to a very serious impact. We do not routinely collect information on the abuse or alleged abuse of people other than those using services, so abuse on staff, for example, does not form part of our notifications analysis.

Across the notifications we reviewed, there are differing levels of evidence. Some notifications give a brief description of alleged incidents to ensure compliance, whereas others give a more complete picture of the incident and the outcomes. We are working to improve the quality of information we receive from providers (see ['Our recommendations for action'](#)).

We discuss potential issues with the quality of the notifications information in the previous section, and urge readers to treat the notifications findings as suggestive rather than definitive. This is why we have used them as part of our analysis, and supported them with findings from people who use services, providers and other stakeholders.

From the three-month period we reviewed, we identified and analysed 661 statutory notifications that described 899 sexual incidents or incidents of alleged sexual abuse that took place in adult social care services. These notifications were around 3% of the total notifications of abuse or allegations of abuse we received in this period.

By their nature, notifications tend to describe situations where things have gone wrong, and do not tend to reflect the huge amount of compassionate care and support given to around a million people³ in adult social care, and the important relationships that are built between them and people using services.

Supporting people to have safe sexual relationships

We would not normally expect consensual activity to be contained in the notifications we receive, but they made up 5% of incidents in the notifications we reviewed. Within these, we saw little evidence that staff were supporting sexual relationships to take place, even where there was no mention that the people concerned lacked capacity or that the behaviour was abusive. In some cases, the notifications containing consensual activity indicated that staff did not fully understand the issues, potentially leading to an infringement in people's human rights.

“Staff witnessed [the man] with his hands down the front of [the woman's] trousers and appeared to be making a stroking motion. She had her hands placed over his crotch area over his trousers and her head lay on his shoulder. Staff intervened immediately and assisted both residents to separate using distraction techniques.”
(Excerpt from notification)

Another example indicates that some staff accept sexual relationships as a natural aspect of life, but that there may not be a consistent understanding and approach between staff. Our *Relationships and sexuality in adult social care services* guidance says that staff should support people to understand sexuality and relationships, and that frank conversations can help develop trust and improve care planning.

“A night staff member was doing her night checks when she went into a bedroom and saw [two residents] having sex. She reported it to another staff member who went along to the room. As she got there [the man] was putting his trousers back on and [the woman] was laughing. She asked them both if all was OK and they both said ‘yes’.” (Excerpt from notification)

There was little reference in the notifications to policies or procedures to support sexual or romantic relationships involving people who use services. However, we have heard of examples where care workers have supported individuals positively and sensitively, including those who identify as lesbian, gay, bisexual, transgender and other identities (LGBT+) (Box A).

Box A: Supporting people who identify as LGBT+

An older man lived in a care home. He had a photo on his table, which had been taken when he was younger and in the armed forces. The photo showed another man. His care worker realised it might have some significance and asked him gently about the picture.

Over time the gentleman felt increasingly able to open up and talk about his relationship with the man in the photo. He had never told his family about it and had kept it a secret for his whole life. Only in the care home was he finally able to talk openly about his sexual orientation, thanks to the relationship and trust built with the care worker.

Source: Example from our regulatory work and engagement

Types of sexual incident

From the descriptions provided in the notifications, almost half (48%) of the reported incidents were categorised as sexual assault, defined as sexually touching another person without their consent. One such incident occurred in a care home.

“Staff were alerted by a sensor mat in the resident’s room. A male resident was seen over the lady holding her hands and moving in a sexual way. Staff told him to get away from her, which he did. She was crying. Staff comforted her.”

(Excerpt from notification)

The second most common type of incident (11%) was exposure and nudity. One incident describes “a man displaying sexual behaviour in inappropriate places. He was continuously removing his trousers and revealing his private parts”.

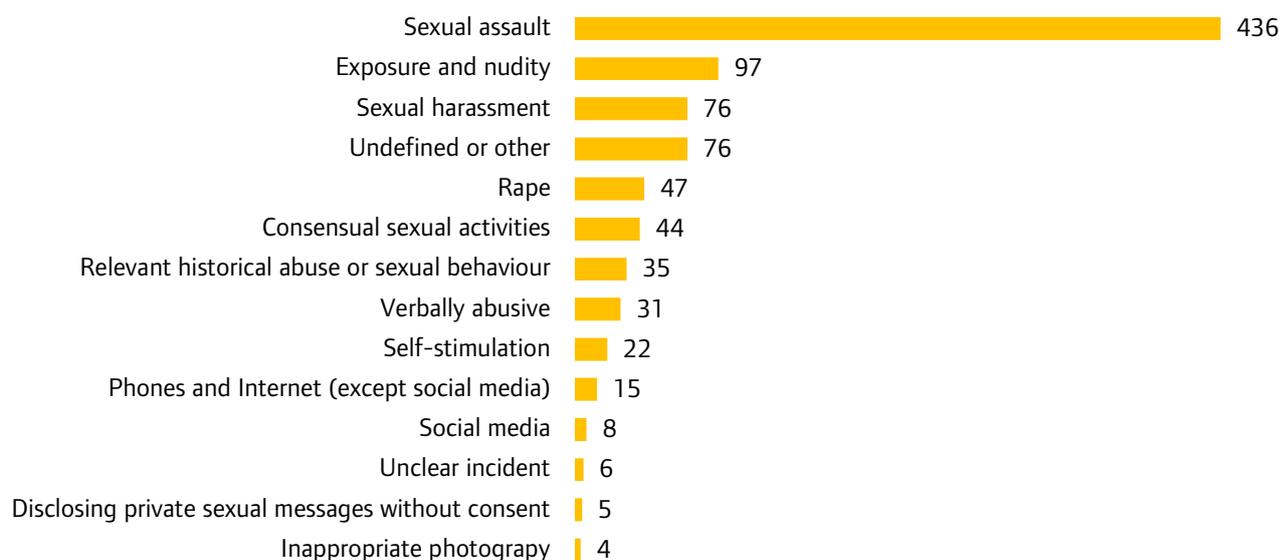
One in 12 incidents (8%) were categorised as sexual harassment.ⁱ In one case, a woman was seen to be “lifting her dress up and trying to coax another male resident to come over to her”.

There were 47 (5%) allegations of rape. For example, a woman who had a learning disability reported to her nurse that her ex-boyfriend made her have sex. When she said she did not want to have intercourse he insisted, saying he wanted to have fun. She tried to use her mobile phone to seek help, but he knocked it from her hand. As for all such notifications, CQC has followed up the alleged rapes with providers to ensure they have addressed incidents appropriately, including involving relevant agencies such as the police, safeguarding teams and the local authorities.

The category ‘Undefined or other’, which made up 8% of incidents, included grooming and giving intimate care without appropriate respect and dignity. In one case, a man sent online photos of his genitals to a woman receiving support in Shared Lives accommodation, using a fake social media account. Before this was discovered by a Shared Lives carer, the woman had sent the man pictures of herself and had arranged to meet him.

ⁱ Defined in the Equalities Act 2010 section 26, and the Sexual Offences Act 2003.

Figure 1: Types of incidents



Source: CQC statutory notifications March to May 2018

People involved in sexual incidents

People carrying out alleged sexual incidents

In the period of our review, most incidents were alleged to be carried out by people who use services (nearly 60% of the notifications). In 16% of cases, the alleged incidents were carried out by employed staff or visiting workers, and in 8% of cases, it was friends or relatives. A substantial number of notifications did not specify the relationship of the alleged abuser to the victim.

Although sexual incidents are not as common as other types of incidents that are notified to CQC, our findings show that they were nearly four times more likely to be carried out by men (485) than women (126) during the period reviewed. Twenty-five per cent of incidents, where age and gender were reported, were carried out by men aged between 75 and 84. Age and gender were not always reported.

Some of the people carrying out incidents were reported to be lacking mental capacity to consent to a sexual activity, or lived with neurological conditions, such as dementia. In 36 incidents, the person carrying out sexual incidents was reported to be lacking capacity, with no further explanation of how that impacted their actions. In 85 incidents the person carrying out the incident was reported to live with a condition that affects their mental health.

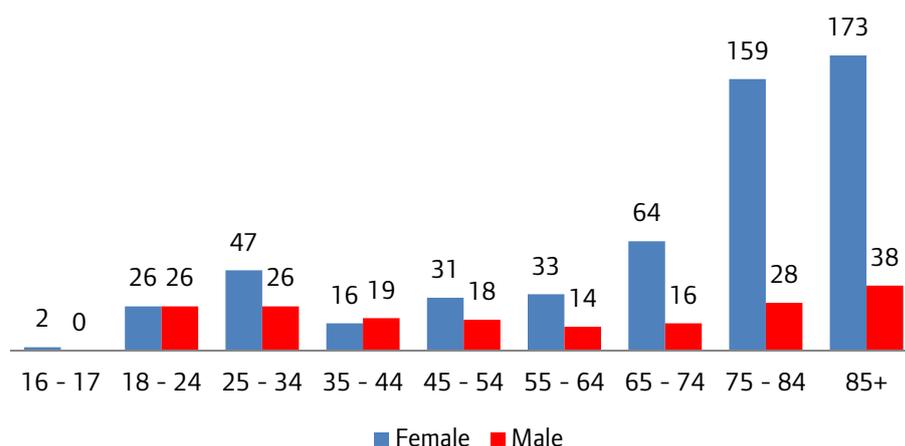
People affected by alleged sexual incidents

The vast majority of people affected by sexual incidents were people who use services. Providers are only required to notify CQC about alleged abuse of people who use regulated services, although we were also notified of a small proportion of incidents involving staff, family, friends and others.

Women were over three times more likely to be affected by sexual incidents than men during the period reviewed.

In terms of age, 45% of all people affected were women aged 75 and over in our findings (figure 2). In contrast, where men were affected, they were more likely to be from a range of age groups, although the largest age bracket was men aged 85 and over.

Figure 2: The age and gender of people affected by incidents



Source: CQC statutory notifications March to May 2018

In 58 incidents the person affected was reported to lack mental capacity generally, and in 113 incidents the person affected lived with a condition that affects their mental health.

In 322 notifications, one or more of the people affected were living with a form of disability, such as a learning, sensory or other physical disability.

We had information on the sexual orientation and gender identity of 635 people affected. Around 70% were reported to be heterosexual, while just over 1% were lesbian, bisexual, gay or transsexual. Of the remaining people affected, their sexual orientation was listed as 'other' in 2% and unknown in 26% of cases. This 'unknown' figure is notably high, given that our *Relationships and sexuality* guidance says that sexual orientation is an important part of people's needs assessment. This could support research and feedback from LGBT+ representatives that people from the LGBT+ community are not always asked, or do not always feel safe, to disclose their sexual orientation.

We also had information on the ethnicity of 717 people affected: 92% were White, with the remainder coming from a variety of ethnic backgrounds. To put this in context, 89% of people using adult social care services reported their ethnicity as White in 2017/18.⁴

Where the incidents took place

Of the 661 notifications we looked at, 86% were from either a residential care home (303 notifications – 46%), a nursing home (184 notifications – 28%), or from a domiciliary care service (81 notifications – 12%). The remaining 93 notifications were sent from a range of

services, such as supported living, Shared Lives, and extra care housing (2.5%) or from services that provide more than one type of care provision (11.5%).

Most alleged incidents took place within the care provider setting (221 incidents happened in communal areas and 214 in private areas such as bedrooms and bathrooms). A much smaller proportion (34 incidents) happened outside of the care provider setting, such as on the street, in parks, pubs, discos and other locations.

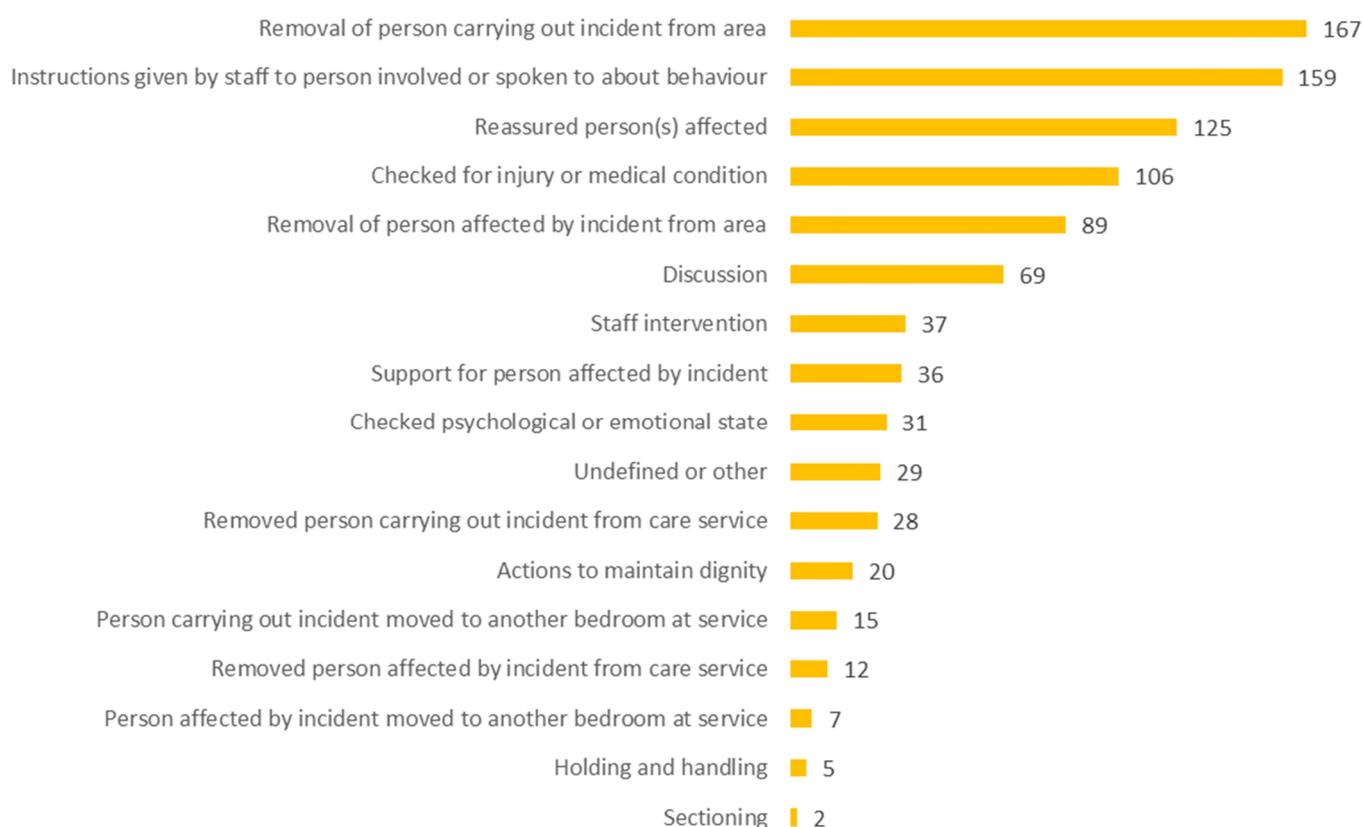
Response by the provider to the incident

Nearly all the incident descriptions had some information about what care providers did in response to the individual incidents (figure 3).

On the whole, providers spoke about how they had sensitively managed incidents. Managers and staff reported that they intervened and prevented or stopped any sexualised behaviours as soon as they could. For example, they would remove the person carrying out the behaviour from the area, give clear instructions for staff and all those involved to manage the person's future behaviour, provide additional support where required, and take actions to protect individuals' dignity. While monitoring and observation was often put in place, staff rarely restrained or detained people. On occasion, providers reported that they had given people notice to leave.

Providers would sometimes remove the person affected by the incident from the area for their wellbeing, providing reassurance and additional monitoring and support. They were checked for injuries or medical conditions, such as urinary tract infections, but were rarely given access to counselling, medication or sent to hospital for treatment.

Figure 3. Short-term provider responses to incidents



Source: CQC statutory notifications March to May 2018

Providers carried out investigations with staff and managers where appropriate, ensuring that families were informed of incidents. Actions nearly always involved local authority safeguarding teams and often police authorities.

Where staff and agency workers had potentially sexually abused a person, these were investigated, disciplinary action taken, and the appropriate agencies advised as necessary. These agencies include local authorities, the police, the Disclosure and Barring Service and other regulators, such as the Nursing and Midwifery Council and Social Work England. In the rare cases that training for staff was mentioned, it was about providing personal care, as opposed to supporting people to have consensual sexual relationships.

Advice was often requested from GPs and social and mental health workers. Few referrals were made to specialist teams or advocacy organisations, such as advice for people with learning disabilities and people living with dementia. Staff suggested that individuals seek advice from sexual health or family planning clinics on only four occasions.

In the longer term, risk assessments, care plans, behaviours and medication were reviewed. There were few instances reported where mental capacity assessments had been carried out as a result of an incident taking place, and fewer still that included assessing people's capacity to consent to a sexual act. There will be times when it is necessary to carry out an assessment of a person's capacity to consent to sexual relations. By law, both parties must

consent to sex. Further information about what to do if someone lacks capacity to consent to sexual relations, and how people's capacity to consent to sexual relations is assessed, is detailed in our guidance on *Relationships and sexuality in adult social care services*.

Findings from our wider engagement

Information from notifications and inspection activities only gives us a partial perspective. To help us better understand the bigger picture, we have engaged with a wide range of stakeholders to ensure that we are able to understand the issues from a variety of perspectives. As part of this review, we spoke to people who use services and their families and carers, including those who have been involved in sexual safety incidents. We also spoke to care providers, charities and other stakeholders.

We asked for their views on whether people using services are currently being kept safe from harm, and what could be done to improve sexual safety and to support people's sexuality in adult social care services.

A lack of openness about issues of sex and sexuality

Stakeholders told us that sex is often seen as a 'taboo' subject. Staff, providers and families can be reluctant to raise issues. The perception is that sex is not something that should be discussed and that people using social care services are not seen as having sexual rights, needs or identities. The lack of openness affects people's wellbeing, but also means that, where there is unacceptable or predatory behaviour, this can be overlooked or normalised.

Providers' unwillingness to talk about sex can be due to uncertainty about the issue, a fear of getting things wrong, or a fear of enforcement or litigation as a result of reporting. This is understandable when there is a lack of guidance for providers – see '[Our recommendations for action](#)'.

Support for people using services and staff

People who use adult social care services, their families and carers told us that there will always be people who do not feel that they can speak out when they have experienced or been harmed by a sexual incident. In a closed environment, people may not be able to open up because they are afraid of retribution. People using services said they were worried that staff would not listen, take their experiences seriously or believe them if they complain.

Care worker advocates told us that staff are also affected by sexual incidents and experience sexual harm, and that staff can, and should, report these incidents to their managers where they should be recognised and dealt with. It is not acceptable for this to be seen as a hazard of the job.

Families and carers told us their loved ones are not always kept safe after an incident has happened. There were also concerns that people do not get access to help and support after these incidents occur, such as therapy or counselling. We were also told of a lack of legal support, advocacy, and communications support for people who use services and their families.

However, we did hear about providers that have developed ideas and processes to support people and staff, which are highlighted throughout this report. This support not only serves to help people express their sexuality, but can also prevent incidents by intervening before they happen.

Box B: Supporting people to maintain and develop relationships

A care home that provides residential, nursing and dementia care for up to 75 people has looked at different ways to support its residents to maintain and develop relationships.

For example, it makes sure that one resident, who is in a same-sex relationship with someone from outside the home, has private time so they can be together. They also attended a 'couples dinner' that had been organised by the manager for the residents.

The manager described this sort of support as "making new memories" and "facilitating residents to enjoy a normal life and maintain important relationships".

The manager has consciously developed the confidence among her staff in having conversations about sex with the people using the service, including the older residents. This has helped them to manage some difficult situations respectfully, such as supporting a person who found their loved one holding hands with another resident, or supporting a daughter whose parent started a new relationship with someone living in the home.

Source: Example from our regulatory work and engagement

Staff development

Upholding the human rights and promoting the dignity of everyone who uses and works in adult social care is at the heart of keeping people safe and enabling them to live with dignity and respect. Organisations that are led by a set of values of person-centred care, which are promoted in their recruitment and work practices, have a strong basis for protecting people from harm.

The culture and policies set by providers tend to be risk-averse; it can seem easier to have blanket rules that discourage sexual relationships rather than individual support, but this clearly can have a negative impact on people's wellbeing.

All the groups we talked to raised concerns about a lack of, or insufficient, learning and development, training and policies for staff on sexual safety and how to support people's sexuality:

- Staff should feel confident to support people to have safe relationships.
- Staff should feel confident to speak up if they have concerns about harmful behaviour of people who use services or other staff.
- Providers and staff need to have an in-depth understanding of people's preferred method of communication and level of understanding, so that they can support them appropriately to explore their sexuality while remaining safe.
- Establishing consent to a sexual relationship can be difficult, particularly where there are complex scenarios, such as when couples are living with dementia. Providers should

therefore understand their responsibilities under the Mental Capacity Act 2005, including when and how to assess capacity to consent.

- There was concern that staff may not be able to recognise predatory behaviour or if someone is being groomed.
- Where people are not able to communicate verbally, they may develop behaviours that demonstrate their distress. Staff should look behind the behaviour to understand its cause, not just deal with the behaviour.
- Providers lack case study examples of what to do in different scenarios and should be aware of the need to balance sexuality needs and risk of harm.
- Some frontline care workers felt they were not always supported by managers, and that in some cases their wellbeing and safety was not prioritised or supported. Providers should have clear policies to protect staff from abuse and processes to report incidents.

Risk assessments

Some of our stakeholders were not confident that adult social care providers were learning from past incidents, particularly in understanding risk assessment policies to protect people. They advised that more information should be shared more effectively between agencies and providers, such as when people are on the Violent and Sex Offender Register.

Care environments

People who use services, especially those with learning disabilities, spoke about care home staff or other people using services wandering into their rooms without their permission. They felt that staff should monitor access to rooms and staff should knock and wait for permission to enter people's rooms. They thought that providers could use developments in technology to improve the monitoring of people's safety.

As part of our co-production, an organisation representing people with a learning disability told us that future guidance needs to recognise and emphasise the increased vulnerability of people with a learning disability or autistic people to sexual harm within care settings, and that they may have greater difficulty talking about issues. We were also told that people with a learning disability or autistic people may have limited knowledge about sex and sexuality, so rely on staff to be proactive in helping them receive advice and education.

We were also told about issues where staff mainly work on their own, as it is harder to corroborate conflicting accounts of incidents. Concern was also raised about care staff in all services who work alone at night and are rarely subject to direct supervision or spot checks, especially where they are able to use their own personal mobile phones in people's rooms. This perception was further highlighted by stakeholders who felt that domiciliary staff were unsupported and left to their own devices and instincts to deal with difficult situations. Care workers also told us that they had been told to always put the person they are supporting first, to ensure they were happy and to put up with inappropriate behaviour.

The variety of settings across adult social care means they need different approaches in dealing with issues of sexuality and sexual safety. One stakeholder said, "For example, in

residential settings the risks and constraints are different, as there are other residents and visitors to be considered, as well as care staff.”

Stakeholders also told us that the type of package of care could affect the time and focus that might be available to support sexuality and sexual safety. One attendee at one of our co-production events said:

“I also suspect that, particularly for council-funded home-care packages, there simply isn’t time to support a person’s sexuality or how they may wish to express it. The broader challenge with home-care packages is how to facilitate or, indeed, refuse certain demands without offending or upsetting the person using the service, particularly if the latter is privately funding their care package.”

Stakeholders felt that common principles were needed to support learning more widely, with a recognition that different settings and different groups of people may also need bespoke approaches.

Our learning

This section summarises what we have learned and concluded from analysing the notifications submitted to CQC by adult social care providers and the views of stakeholders who have supported our review.

Stakeholders are concerned about the sexual safety of people using adult social care. They told us that discussing or recognising the sexual lives of individuals, especially older people, is a ‘taboo’ subject in too many services. Or that there are ‘normalised’ attitudes where harmful behaviours are accepted and unchallenged. The right to have a private and family life (Article 8), and freedom from torture and inhuman or degrading treatment (Article 3) are articles of the European Convention on Human Rights which are legally enshrined within the Human Rights Act 1998⁵ and providers have a duty to promote this in their service, including for their staff.

Stakeholders linked the ability to speak openly about healthy sexual lives with a greater understanding of potentially harmful behaviours – whether they are pre-meditated or because of impaired cognitive ability or neurological conditions.

By contrast, where sexual harm occurs, it may not be understood or dealt with effectively. In some cases, we heard directly from providers that they were not willing to talk about the subjects of sexual safety and sexuality with the people who use their services, especially in regard to older people.

However, we also found clear examples of good practice in the sector and an eagerness to be involved in the discussions around improvement (Box C).

Box C: Principles of good practice

Throughout this review, we have identified good practice principles that help to promote sexual safety and support people’s sexuality in adult social care. Much of this good practice has been seen in services for people with learning disabilities, but we believe it can be adapted to use in all adult social care services.

- Leaders should promote a culture of openness that allows people to both discuss issues of sexuality and raise issues of sexual safety, as part of a holistic approach to good person-centred care.
- People receiving adult social care are entitled to the same human rights as anyone else, and should be afforded the same dignity, choice, family life, privacy and respect, and should be able to feel safe from sexual harm.
- People who use services should be central to conversations about their needs and choices. Where seen as supportive and agreed to, family members, carers and advocates can also be included.
- Assessments should include information about people’s sexuality needs (including current relationships, sexual orientation and understanding of sexual health, where

appropriate) as well as any past criminal or predatory behaviour. Care plans should accurately reflect these assessments and note the needs and wishes of people.

- Training should include supporting staff to have informal, everyday conversations about sexuality and sexual safety.
- Recruitment and organisational values should have a human rights focus.
- Providers should work with relevant community groups to give staff and people who use services support and access to information on sexual safety and sexuality.

There was a broad consensus on the key themes and action needed to improve sexual safety for people, and there was a strong request that national guidance is developed and co-produced to support this.

1. People are better protected when they are empowered to speak out about unwanted sexual behaviour and can speak openly about their sexuality

People who use adult social care services, their families and carers should feel confident about speaking out about their experiences. They should feel listened to, and providers should take their feedback and complaints seriously.

People who might find it difficult to speak out should be supported to explain what has happened to them. This may be because they have communication difficulties or lack capacity to retain information or make decisions.

People are less likely to speak out in closed cultures, where they may doubt anything will be done with their feedback or, worse, if they think it might adversely affect the service they receive. People will also stay silent if they see others not receiving the care and support needed after a sexual incident.

We know from our regulatory work that closed cultures are more likely where:

- people are situated away from their communities
- people may stay for long periods of time
- staff often lack the right skills, training or experience to support people
- management have poor oversight of the frontline care being provided.

We are aware that these cultures are more likely to develop in certain services, and have recently issued inspectors with [supporting information on closed cultures](#) that sets out the risk factors and how our inspectors should respond to these.⁶

Our findings show that 16% of sexual safety incidents recorded in notifications were carried out by employed staff or visiting professionals, such as nurses. This may indicate issues with recruitment practice in adult social care services or perhaps the level of lone working that can leave people more vulnerable.

Our findings also show that 8% of incidents reported during this period were carried out by friends or relatives. CQC staff reported that they have taken action because staff have told them about domestic abuse in both residential and domiciliary care, but they are concerned that other cases can remain hidden because managers and staff lack the confidence to address them.

How can this be addressed?

Staff should be alert to any report of a sexual safety incident made by people who use services, their families or carers. It is important for staff to understand changes in behaviour that could indicate something is wrong, particularly where people lack capacity or may, for any reason, have difficulty disclosing what has happened to them. This can be difficult since there are few resources that staff and providers have access to, or they may not know what is available (Box D describes two resources).

The person, or their family or carer if appropriate, should be involved in agreeing the actions to be taken. If, having investigated, the allegations are found to be unfounded, staff should still find out why the person made the allegation and respond to any distress felt by all associated.

Box D: Resources for staff and people who use services

Supported Loving is a human rights campaign and national network that works closely with people with learning disabilities and providers to support loving relationships. They have produced a toolkit that covers effective policy-making for care providers, supporting sexual relationships and understanding harmful sexual behaviour. It brings these issues together to provide a holistic perspective on these issues.

The Alzheimer's Society have developed a workshop on sex, intimacy and dementia that explains consent, such as non-verbal consent, the practicalities of sex in a care home, sexuality policies and related issues. It looks at the importance of intimacy and how this can be encouraged.

Links to the both resources can be found in the [Links to useful information section](#) of this report.

Providers must make sure that the systems and processes that they use help to create a culture that keeps people safe. This can be done by reviewing sexuality, safety and recruitment policies, fostering an atmosphere of openness and trust and taking action quickly to protect people.

Staff must make sure that the people they care for feel supported and can speak freely. Developing a culture in the service where people are encouraged to speak up about anything that they are concerned with, with the confidence that it will be taken seriously, will help people to speak up about more difficult experiences. For example, services for people with a learning disability can follow the principles of 'Ask Listen Do'.⁷

Providers must ensure that staff have appropriate training and support to be able to speak up. Open conversations are more likely to take place when close working relationships form between people using services and consistent, committed staff. This is a positive sign of developing trust between them.

At the same time, staff should understand professional boundaries, ensuring they can clearly communicate what behaviours are not acceptable and how the service responds to sexual safety incidents. Setting clear boundaries can be especially difficult for domiciliary care staff. Frontline care workers therefore need support from their managers and leaders to feel confident to do that. Some services promoted a culture of openness through the simplest of interventions – for example, by having regular conversations, often separately with staff at team meetings, to allow staff and people using services to raise issues, talk about their feelings or ask questions.

However, providers should acknowledge that people may be reluctant to speak to staff for fear that it may damage a relationship that they feel dependent on, or because they do not feel comfortable. People should therefore be supported to speak out through access to advocates, or be given help to communicate if needed.

2. Effective adult social care leaders develop a culture, an environment, care planning and processes that keep people and staff safe, and support people’s sexuality and relationship needs

A concerning picture from some of the most harmful sexual incidents reviewed as part of this report show some services that have allowed harmful behaviours to be accepted and unchallenged. People who use services are not protected from harm where a lack of respect or knowledge becomes a normalised part of working practice.

In our analysis, the notifications to CQC we looked at varied greatly. For example, some notifications of abuse describe sexual activity that we would consider consensual. There did not seem to be a clear understanding of what constitutes sexual harm and how to report it to CQC.

“Both appear to want to engage in sexual activity, and believe they are in a relationship. Staff try to keep them apart, but the female resident becomes aggressive if they try. It was noted that the male was rubbing her private parts. When staff intervened, the female tried to put his hand back.” (Excerpt from notification)

A lack of understanding of what constitutes sexual harm can have two effects. One is that staff do not report incidents when they should. The second is that staff reactively report incidents when it would be better to consider whether a more supportive course of action would be more appropriate. In either case, people’s needs will not be met and there is a real risk that they will be put at risk of harm, or not provided with appropriate education or support to have safe, meaningful relationships.

These staff behaviours persist in a risk-averse culture, where people and staff do not feel comfortable to talk about sexual safety and sexuality.

In adult social care, people can live with conditions that affect their sexual behaviour. When an incident happens, what is important is how the service approaches safety – both as a preventive measure to deal with risks, and in supporting people to recover from incidents. Where there is pre-meditated, predatory sexual behaviour, the quick action of the provider to remove the identified person, and the support and communication with the victim will prevent further distress and protect people and staff.

How can this be addressed?

It is the leader's job to shape the culture of an organisation. They are responsible for developing a culture that is intolerant of unacceptable sexual behaviour, and is open in encouraging staff and people using services to report and discuss sexual safety incidents, as well as sexuality and relationship needs.

Staff should be supported to understand the difference between sexual abuse and consensual sexual activity. They can only do this if they have the right opportunity and forum to talk with colleagues and supervisors about their concerns and opportunities to support people. Staff are much more likely to speak up if there is a culture of openness rather than a blame culture.

As part of inspiring and facilitating high-quality, person-centred care, leaders must encourage best practice to prevent, report and proactively respond to sexual safety incidents, and work with staff to create a culture that supports people's relationships and sexuality. Through care assessment and planning, as well as their everyday care, staff should be able to recognise the changes in physical appearance, feelings and behaviours that indicate sexual abuse and harassment of people who use services. Staff should also be able to recognise suspicious behaviour and raise concerns with the confidence that they will be taken seriously.

To develop this culture, staff themselves must feel safe from unwanted sexual behaviour and know that if they report a sexual safety incident, it will be acted on. They should also feel that they would be supported fairly when faced with allegations of a sexual nature.

Although CQC does not routinely collect data on staff experience of sexual harm, care worker advocates told us that it does happen. Openness in the workplace, trust and good relationships between management and care workers are important in preventing staff from being affected by sexual incidents. Staff can, and should, report these incidents to their managers where they should be recognised and appropriate steps taken. These stakeholders also said that the safety of people using services and staff should be prioritised and made an integral part of an organisation's values.

People expect sexual safety incidents to be taken seriously. Providers must have processes in place to monitor the quality of reporting, learn from past experiences, and ensure that actions are taken to improve the sexual safety of people using services. People using services and their families and carers should be involved in planning these actions and improvements.

Box E: Designing an environment and processes that support residents' sexuality and sexual safety

A residential care home thought creatively about the physical environment for the older people living there, and their experience of living together, when they converted a former hotel. They built an internal village with village square, daylight 'lighting' and street lights to help day and night orientation, shops, church, pub, tea room, 1950s kitchen complete with working Aga, and an indoor 'garden' which links to an outdoor garden.

This means their residents have many safe places to visit, which reduces episodes of aggression or frustration. The bedroom corridors are accessible only by electronic fob, and residents are assessed for capacity to safely retain and use their own fob.

They considered issues of sexuality and keeping people safe from sexual harm at the outset, because they wanted to encourage people to engage and interact in the home's environment. They made these issues central to their recruitment processes so that they only employed people who were comfortable speaking and dealing with sexuality and sexual harm (with each other and people living in the service) and provide access to resources for them to learn and develop in this area.

They find that people and staff are able to interact together with confidence to approach issues of both sexuality and sexual safety. Staff are also able to discuss these issues with each other and flag any concerns openly in a supportive environment.

Source: Example from our regulatory work and engagement

3. People want to be able to form and maintain safe sexual relationships if they wish

People who use adult social care services, their families and carers told us that people are not always supported to talk freely about their sexuality or sexual relationships, or given privacy to have a sex life. If they talk about sex, they are not listened to, or they are treated as if they have done something wrong.

People want their sexuality needs to be accepted as part of their everyday lives, regardless of age, their sexual orientation, or their care needs. This is a human right and part of being treated with dignity. They would also like to be fully involved in discussions, where relevant, to support their relationships and sexuality in a safe and agreed way.

"A gentleman resided on our all male unit. There was a large picture on the corridor wall. The lady in the picture had a mass of curly red hair. She looked somewhat like his partner. Initially he was noted to talk to it, then proceeded to kiss the picture. He was clearly showing some attachment needs. This developed to him masturbating while in front of it. Unfortunately, the picture was located at the T-junction of the corridor. This was not dignified for him and other residents and visitors. We moved the picture into his room, which maintained his privacy."

(Excerpt from a notification)

However, it is clear from our engagement with people using services, their representatives and providers that sexuality is still a difficult area for many parts of adult social care and for staff. For some, it may be controversial – even a taboo. Providers need to recognise and support people’s sexuality needs, or they may risk discriminating against them or breaching their human rights.

Box F: Support for a transsexual woman at a supported living provider

M is a transsexual woman with learning needs. She is not able to go back to her family home, and has no contact with her Dad and minimal contact with her Mum. Her Nan is the most involved and supportive member of the family. She is currently transitioning and was unhappy with the lack of support in her original supported living placement.

M’s new supported living provider embraced her choice to dress and act as a woman. They worked with the specialist sexual health nurse to support her to investigate a surgical and medical intervention to transition to her preferred gender.

This is progressing slowly as her clinic needs to see that M is consistent in her behaviour and decisions. In the meantime, M has grown in confidence and has taken on a job with the local police.

Source: Example from our regulatory work and engagement

There are some excellent examples of providers and staff supporting people’s sexuality, some of which are included in this report. However, our sense is that these examples are the exception. The adult social care sector, as a whole, needs to be more confident in making people’s sexuality needs a central aspect of care planning and support.

How can this be addressed?

Those involved in the care of people in adult social care services should be aware of, and sensitive to, people’s sexuality and relationship needs. Staff should recognise that it is healthy for people to experience sexual feelings and desires, and to want to express sexuality in their everyday lives. Staff should not treat consensual sexual activity as harmful.

Care plans and risk assessments should indicate that people’s needs have been considered and that support and education has been offered to meet those needs – for example, where a person has expressed their sexuality or are in a relationship. Care plans should also indicate where people exhibit heightened sexual behaviour or sexual disinhibition to help protect and support the individual, other people using the service and staff.

Box G: Clear care planning for consistent support

It is important to have a clear policy and individual care plans that are tailored to fit people’s individual needs. Without this support, staff may make personal judgements based on their own values and experiences, rather than a clear organisational stance. This can lead to a lack of consistency in support regarding sexuality and relationships. For example:

A lives in a supported living house with 24-hour support. He likes to stay overnight in his boyfriend J's house most Saturdays. However, sometimes staff (especially new or agency staff) give different responses when A tells them about this, such as "I am not sure we allow that", or "I need to call the manager to ask". Understandably, this upsets A and can result in him shouting at staff. The team have now created a care plan that is clear about A's relationship, indicates to staff that A has the right (and is able) to do this, and gives information about A's location (he also has a mobile phone in case of emergency).

Source: Supported Loving – see '[Links to useful information](#)'

It is important to understand and recognise the vulnerability of many people who use adult social care services. Stakeholders told us that isolation, loneliness and boredom contributes to people's vulnerability. This could result in a lack of confidence to discuss sex and feelings, which can increase the likelihood of people being subject to sexual harm or lead to inappropriate sexual behaviour.

A personalised approach to care-giving, accessible information and supported decision-making will enable people and staff to have conversations about sexuality, relationships and related issues. Through the process of developing this shared understanding, people will be better protected as they understand feelings, boundaries and what constitutes good and bad relationships.

Box H: Supporting people to develop relationships as part of holistic care planning

K is a young woman who lives in a residential home for people with learning disabilities and physical disabilities. She has a learning disability and has periods of mental ill health and other physical health concerns. Before moving to the home, she had limited ability to engage in social activities and to form relationships with others.

In 2018, K went to a gig in a local pub. She chatted to the lead singer (A) after the gig and found that they had lots in common, including the year they were born and their shared passion for 80s music. K felt butterflies in her stomach and just couldn't stop thinking about him afterwards.

They chatted online for a while before exchanging numbers. They then began to call each other regularly and the relationship grew steadily from there.

A was welcomed into K's home. They cook meals together, watch TV and listen to music as any other young couple might do. Out of respect for the other people living in the home, they have agreed to avoid 'heavy petting' in communal areas, though they spend time in K's room. She sometimes hangs a 'do not disturb' sign on her door.

Despite the excitement of falling in love, K also felt anxious, probably resulting from her previous experiences and mental health concerns. Staff have supported K at every stage positively and respectfully. They have offered appropriate advice on the intimate side of K's relationship when she has asked for it. This means that K and A have been confident

in progressing the relationship at their own pace as well as understanding how to remain safe.

K's family have been equally supportive and have worked with the staff very closely to ensure that there has been consistency in the support and advice provided.

The two of them are now engaged to be married. A proposed at a disco in K's home, on bended knee with all of their friends and staff there to help celebrate.

The couple want to move in together after they have married. The home, alongside family members, are currently working with the two commissioning authorities involved with K and A's ongoing support needs to develop a pathway plan to enable them to live together and receive the ongoing support that both of them will require.

In the meantime, K is still 'buzzing' and still very much in love.

Source: Example from our regulatory work and engagement

As the sector develops good practice in this area, it is important that providers share their experiences so that others can learn from them. This is more likely to occur currently across services within a larger corporate organisation, but it is important that peer learning can happen between different providers.

Box I: Co-producing training with self-advocates

A community interest company in Lancashire developed a six-week course with self-advocates who have a learning disability and their supporters. The course aimed to help people:

- understand how our bodies work
- be more confident in discussing sexual matters
- be aware of sexual rights and responsibilities
- to know where to go for help and information
- to understand different types of relationships
- to know how to have safe relationships
- to have fun and enjoy ourselves.

People reported being more confident and comfortable in discussing relationships and sexuality issues afterwards. Since then a number of people have gone on to be trainers and are able to cascade the resources within their own groups.

Source: Supported Loving – see '[Links to useful information](#)'

4. The impact of people's health conditions on sexual behaviour is not well understood

People who use adult social care services have a range of health conditions that may increase their vulnerability. These conditions include different types of dementia, learning disabilities and brain injuries. These can fundamentally affect a person's behaviour or their ability to defend themselves or communicate that they have been harmed. Sometimes conditions can affect people's sexual behaviour – for example, they may have heightened sexual awareness or needs, or be sexually disinhibited. People can act inappropriately without realising the consequences of their actions or that what they are doing is putting other people at harm. Sexual disinhibition displayed by someone living with dementia could be a sign that they are struggling to meet their sexuality needs. It is important for all involved, including partners and family members, to be helped to understand these conditions better so that they can be supported, and not to confuse them with harmful intent.

However, where a person has been sexually assaulted or harmed, the actions taken to protect the victim must be the same as with all serious incidents. Providers must recognise the victim's distress and support their needs. The person carrying out these types of incidents is likely to also need support. Where this is unlikely to change sexual behaviour, an assessment must be made as to the safety of all people and staff within the setting, and a course of action decided and agreed with relevant people.

A person may lack the mental capacity to consent to sexual relations or activity, or understand their own behaviour. However, each person and situation is different. Mental capacity should be assumed unless it is proved otherwise.

This is a complex and sensitive area, but it is important for those working in adult social care to understand it better for the benefit of people who use services.

How can this be addressed?

Personalised, holistic care plans, which are aligned to risk assessments and other information held by health and care givers, will help identify people's sexuality needs and reduce the risk of sexual abuse. They will also improve staff and people's understanding of how a particular condition might affect sexual behaviour and how best to support people.

Providers and staff should understand and act on the key principles contained in the Mental Capacity Act 2005 to support people's decision making, which includes assuming someone has capacity unless proved otherwise.

This understanding should be reinforced by better staff development. Training and guidance should be produced in partnership with relevant stakeholders, and must equip staff to:

- Improve their skills and confidence to talk with people who use services, their families and carers about sexuality and sexual safety, using appropriate language.

- Recognise that sexual needs are important for everyone throughout their life, as stated in our *Relationships and sexuality in adult social care services* guidance – “It is healthy to experience sexual feelings and desires, and to want to express sexuality in our everyday lives...Providers need to understand the importance of enabling people to manage their sexuality needs and... to understand the risks associated with people’s sexuality needs.”
- Assess people to include details about their sexual safety and sexuality. This would include their vulnerability and potential to display sexual behaviour that puts others at risk. This will enable staff to sensitively identify potential risks and plan the person’s support as part of their needs assessment.
- Respond to the needs of people across different groups, such as people with a physical disability, people with a learning disability, people living with dementia, older and younger people, and people who identify as LGBT+, Black and minority ethnic or other protected characteristics. We know, for example, from our engagement with people who use adult social care services, that religious and cultural issues can prevent LGBT+ people expressing their needs. This can potentially make them more vulnerable.
- Consider the difficult issues of mental capacity and consent, alongside people using services, their carers and families.

Our guidance on *Relationships and sexuality in adult social care services* gives further information to help providers to understand and implement action to care for people who need support to express their sexuality and to have their needs met.

5. Women, particularly older women, were disproportionately affected by sexual incidents in our findings

A much higher proportion of women aged 75 and over were affected by, or victims of, sexual incidents, particularly sexual assault, in the notifications we reviewed. Although our information was limited, this is still an area of concern.

Stakeholders told us that in wider society older women are not always listened to, or able to communicate concerns. They said this is heightened within adult social care because older women can be further marginalised and isolated from knowledge and support. In some of the worst cases of sexual abuse, staff did not know what to do when sexual assaults happened. Or they normalised these behaviours – for example, staff dismissing behaviour as a personal character trait – ‘oh that’s john, don’t worry he does that’. This can increase vulnerability for women within care and can have devastating, long-lasting effects on victims and their families. Both staff and people within settings have the right not to be abused.

We were told that people should have a choice about who delivers their personal care, but that this does not always happen. One representative of people who use services said during our engagement, “Even though she requested personal care from a female member of staff, the provider still repeatedly sent a male member of staff.”

We heard from stakeholders who support people with a learning disability how loneliness and low self-esteem can increase the likelihood of sexual harm for women of all ages, but that services can act to support change.

How can this be addressed?

Normalising behaviours that can lead to a sexual incident can occur when staff do not have a clear understanding of expected values and behaviours in regard to sexual safety. Our findings show that women can be particularly put at risk when this happens. Within all adult social care settings, there should be a clear explanation of what behaviour is acceptable and unacceptable regarding sexual safety. This can be communicated individually, as well as through information for all staff and those who use services.

As women are broadly more at risk of sexual abuse in society as a whole,⁸ providers can support women through promoting a supportive culture and leadership, effective staff supervision and learning, and ensuring person-centred care. Providers could also engage community women's support groups working on issues of sexual safety to support better understanding and safety practice.

6. There are some actions that providers in all care settings can carry out to help keep people in their service safe from sexual harm

Adult social care is delivered in a variety of settings and environments, including care homes, domiciliary care and supported living services. This means that, although the principles of good practice (Box C, page 27) apply to all services, there will be bespoke guidance needed for different settings – for example domiciliary care and residential homes.

It is important that the environments where care is provided meet the diverse needs of everyone – and do not make assumptions. This may be particularly important for those people with protected characteristics, such as people who identify as LGBT+ and people who identify as Black and minority ethnic.

How can this be addressed?

Stakeholders agreed on the complexity of environments in the adult social care sector, and that no one particular type of environment can be said to be completely safe. They said that key principles should be similar across all environments, but that there are actions that each service can carry out to keep people safe from sexual harm.

Providers should:

- Consider how they carry out risk assessments of the environment, to include considering areas of the service or times of the day where the risks are higher. They could also consider whether technology could improve their overall safety measures, based on people's individual needs. For example, audio sensors in a bedroom can pick up sounds that suggest someone is in discomfort or distress during the night. Personal alarms that

people wear or put in their own homes enable them to call for urgent help when activated. See our [Technology in care](#)⁹ webpage for more information.

- Develop a learning culture within services through discussion and reflective practice. This helps concerns to be escalated and discussed – particularly regarding people’s capacity and human rights, and for groups whose needs are not understood or who can face discrimination and prejudice.
- Make sure staff are all committed to respecting privacy and dignity, such as knocking on doors and waiting.
- Make best use of risk assessments of who lives in residential settings to reduce and manage risks identified between people. Decisions to bring people into a residential service should consider the needs of those who are already there, and providers should continually review people’s changing needs and behaviours so that the mix of people in the service remains appropriate and safe.
- Develop a care planning approach that ensures people lead full lives and retain skills and interests.
- Work with relevant community groups to give staff and people who use services support and access to information and education on sexual safety, sexuality, consent and autonomy to help them understand what is acceptable and not acceptable in issues around relationships.
- Make sure people who have been subject to sexual assault and abuse have access to ongoing support, where local agencies work together to provide multi-agency collaboration. This could include ‘sexual assault referral centres’ and access to therapeutic support, such as ‘trauma-informed approaches to care’ (see [glossary](#)).

Box J: Surviving sexual abuse in a care home

L is a young woman who is autistic. She was raped in her care home by another resident who had a history of sexual abuse.

L was not cared for after she’d been raped and had a seizure shortly afterwards. Staff only called her mother the next day, saying that she had consented to sexual activity. L was not taken to hospital or checked and the police were not notified.

Eventually, L’s case was successfully prosecuted. And five years later, L is doing well in a supported living service where she receives one-to-one support. However, her mother’s journey in finding a good and caring home for her traumatised daughter was not easy. She is keen to share what she learned from this journey.

What L’s mother looked for in a good care setting:

- Transparency is key. The management and the values of the service are totally visible.

- L's mother does not need an appointment to see the service's management and staff. She feels they have nothing to hide. She can see that the staff are happy, and this translates into a happy home.
- There is a parent forum at the service. Parents can see issues in practice and discuss them.
- The mix of people using services is clearly thought out.
- Managers have set up a good, open working space, and make themselves available to speak to anyone.
- When things go wrong the issue is dealt with, and questions are asked about how to improve.

Source: Interview with L's mother

7. There are emerging concerns about the role use of social media, mobile phones and the internet in sexual abuse

There was limited information within the notifications about how social media and digital communication is used by people who carry out incidents. However, our engagement with stakeholders highlighted this as an emerging issue where change is fast paced. People are put at serious risk of sexual harm by being groomed via mobile phones and computers. Loneliness and isolation can increase the likelihood of this happening.

We heard that young people with learning disabilities are particularly vulnerable to grooming on social media. One example was of a young girl who felt lonely, but couldn't distinguish harmful sexual attention from the attention she desired and craved. She would use social media to meet men and have sex with them.

We are also aware that digital technology, especially mobile phones, have been used by sexual predators to abuse people, such as in one of the 'Lived experience' examples at the beginning of this report. In this case, the family of the victim were particularly concerned about the use of personal mobile phones by staff while they are with people who use services.

How can this be addressed?

Providers should ensure they have clear policies to explain how social media and digital technology is used and accessed, and how people using services are supported and protected from misuse: for example, when and how staff use mobile phones and other digital communication when providing personal care, and how people can be kept safe from online grooming or other abuse.

Consideration should also be given to how digital technology and innovation can enable and support keeping people safe. Our [Technology in care](#) webpage discusses online platforms that can be accessed by mobile phones and other devices to improve information sharing and independence.

8. Joint-working with other agencies, such as local authorities and the police, is vital to keep people safe

Our findings highlight the positive ways that providers have responded to sexual safety incidents and how initial investigations with staff and managers have been followed up by involvement with local system partners – in particular with safeguarding authorities and often police authorities. This relationship is important, especially where criminal activity has taken place, but we heard it is not always joined up effectively where victims need to be supported.

Examples of joint working included the following two cases.

“A retrospective notification was made to CQC following dismissal of the manager and a full audit was conducted. It was identified that several incidents on behaviour charts had not been notified. All incidents were also submitted to the local safeguarding authority.” (Example from our regulatory work and engagement)

“The home had inappropriate sexual disinhibited behaviour from a female resident to various male residents in the home. There were five victims of sexual assault who were all male aged 75-84 and 85+.

The dementia outreach team was involved in her care, as were health professionals who visited on several occasions. Through working jointly with the provider they have now discharged her, as the incidents have stopped.” (Example from our regulatory work and engagement)

External assistance was often requested from GPs and social workers, though rarely from specialist teams – for example, for advice in relation to people with learning disabilities and people living with dementia. However, in some cases providers retain in-house specialist skills.

There is a voluntary and community sector locally and nationally that has tools and specialist expertise to support those who are affected by sexual harm and to support the management of sexuality needs. There was little reference to the use of these resources in our notifications, but our engagement with representatives highlighted the support that is available, including advice from sexual health, family planning and sexual violence support organisations.

How can this be addressed?

Providers must work closely with other agencies in their response to sexual safety incidents. Clearer guidance could improve working between different agencies such as police, providers and local safeguarding teams to give the right level of support for victims (see [‘Our recommendations for action’](#)).

Sexual assault referral centres, local rape crisis services and sexual health centres can be crucial to support people who are affected by sexual incidents.

Advocacy services and sexual health centres, as well as related voluntary and community groups, are also a source of information for managing sexuality needs and relationships for people with dementia and learning disabilities. Our [Links to useful information](#) includes a number of tools that have been developed to support those involved with people who use services.

We need to work in partnership with local authorities and commissioners of registered adult social care services to ensure effective information sharing and monitoring systems are in place. This is both to identify services that require additional monitoring and support, but also to ensure placements are of a high quality and meet people's needs.

Our recommendations for action

Our analysis of notifications and engagement with providers, public representatives and other stakeholders has found that people are not always protected from sexual harm or supported to express their sexuality. We have been working closely with national bodies and other stakeholders to agree what needs to be done.

These recommendations, which are based on the feedback we have received, require changes in different settings across adult social care, with the support of the whole local system.

A lack of awareness of good practice in sexual safety and sexuality can place people at risk of harm

1. We recommend that Skills for Care update their guidance on ‘Supporting personal relationships’ to incorporate the learning from this report by Spring 2020. This guidance for care managers and staff should be co-produced with a wide range of stakeholders. We recommend that this should be a practical guide to make sure staff know how to protect people using adult social care from sexual abuse and how to support them to develop and maintain relationships and express their sexuality.

The guidance should include:

- how staff should empower people in any adult social care setting to have the confidence to discuss issues around relationships and their sexuality, which will also keep them safe from sexual harm
- providers’ legal obligation to respect and promote people’s human rights, including their sexual rights
- how certain illnesses and conditions can result in sexually disinhibited behaviours and how to manage these behaviours
- how to recognise the changes in physical appearance, feelings and behaviours that indicate sexual abuse and harassment of people who use services and how to raise issues, while remaining vigilant with those who are unable to articulate their concerns
- how to support people’s understanding and awareness of consent
- how to recognise when someone does not have capacity to consent to sexual relations
- how best to collaborate with local agencies, such as local authority safeguarding teams and the police, and other mainstream services and support groups, such as crisis centres, to make sure that sexual safety incidents are understood, taken seriously and addressed appropriately, and that people are supported
- how best to understand the needs of specific protected characteristic groups to help make sure that people’s person-centred care needs are met

- how digital communication and technology, such as smart phones and apps, can be used positively to support people's sexuality, but also how it can pose a risk to people's safety
- which groups of people are most at risk of being affected by, or carrying out, sexual abuse, based on our findings and those of others.

A culture must be developed where people and staff feel empowered to talk about sexuality and raise concerns around safety

2. We recommend that providers and leaders across the adult social care sector develop a culture, environment and processes that support people's sexuality, keep them and staff safe from sexual harm, and promote people's human rights.

- Staff should be strongly encouraged to access practical learning about the above guidance so that they feel confident to address the issues in this report.
- Staff should be addressing sexuality positively and enabling relationships, and supporting people to raise concerns where necessary.
- Leaders should be visible in promoting sexual safety and in supporting people's sexuality, and knowledgeable about local support systems to promote a culture of openness.
- Staff should be encouraged and supported to have conversations with each other, and speak to managers where they have concerns about the sexual safety or behaviour of people in their care, or concerns about their own safety.
- Care plans and risk assessments should indicate that people's needs have been considered, and that support and education has been offered to meet those needs – for example where a person has expressed their sexuality, or that they are in a relationship or want to develop one.
- Providers should ensure, as part of the process of supporting a person to use their service, that information about their background and history is included as part of a holistic assessment, which includes their input. This includes their sexuality, their current relationships, any health condition that may lead to sexually disinhibited behaviour, or involvement in any previous sexual safety incidents.
- Providers should consider the needs and mix of other residents or household members when supporting a person to use their service.
- Recruitment of staff should be based on values of person-centred care, and the understanding that people have a right to be kept safe from sexual harm and to express their sexuality.
- Providers must work actively to improve the sexual safety of people who use services by promoting access to ongoing support and information. This should be in an accessible format and reflect people's communication needs, culture and diversity.

As the regulator, we have a strong role in making sure that people using services are protected and supported

3. The Care Quality Commission should continue to strengthen our processes to ensure that people's human rights are protected and that they are kept safe from abuse in adult social care services, including sexual abuse, and empowered to make positive relationships, through improved monitoring, risk assessment and inspection.

- CQC has learned lessons from previous handling of sexual abuse incidents and will continue to develop our processes, systems and tools so that we improve how providers notify us of incidents and how we deal with them. This will ensure that CQC staff, including our inspectors and contact centre staff, are more confident in dealing with these difficult and sensitive issues in a timely way.
- CQC will support Skills for Care to ensure that their guidance is developed in co-production with providers, system partners and people who use services and that the guidance is promoted to the sector. This will complement our *Relationships and sexuality in adult social care services* guidance.
- CQC will consider the learning from this report when we update our assessment framework in 2020/21, so that we can improve our regulation and make sure that services are taking the guidance into account.
- CQC will continue to work in partnership with local authorities and commissioners of registered adult social care services to ensure effective information sharing and monitoring systems are in place to identify services that require additional monitoring and support and to ensure placements are of a high quality and meet people's needs.

Glossary

Adult social care sector: adult social care covers a wide range of support and activities to help people who are older or living with a disability or physical or mental illness live independently and stay well and safe. CQC regulates providers of personal care in services, including care homes, domiciliary care agencies and supported living.

Consent: is the ability to be able to give permission for something to happen. Under the Mental Capacity Act (2005), it should be presumed that a person with a learning disability has capacity to consent to sex unless there is evidence to prove otherwise. An individual will have capacity if they have an understanding and awareness of the mechanics of sex and the health risks involved. If they do not understand this, they need to be given support in a suitable format to help them to understand.

Co-production: equal and reciprocal partnerships between service providers, the people who use services and others, to design and deliver services.

LGBT+: describes the lesbian, gay, bisexual, and transgender community. The first three letters (LGB) refer to sexual orientation. The 'T' refers to gender identity. The '+' stands for other marginalised and minority sexuality or gender identities.

Notifications: statutory notifications are reports that care providers are required to send to CQC to inform us of various types of incidents, including abuse and alleged abuse. The forms usually contain information on the service in question, what happened, as well as details about the people involved.

People who have carried out sexual incidents: a person who has carried out sexualised behaviour or activity that has involved another individual directly or indirectly (for example, by witnessing a behaviour). The use of this term does not necessarily imply intent, because incidents can result from sexualised behaviours associated with a person's illness.

People who have been affected by sexual incidents: a person who has been directly involved in or witnessed sexualised behaviour or activity that was carried out by another individual. The use of "affected" includes the potential to be affected both physically and psychologically at the time of the incident and in the future.

People who have been involved in sexual incidents: refers to both people who have carried out sexual incidents and those who have been affected by sexual incidents.

People who lack capacity: A person lacks capacity if their brain or mind is impaired, for example through dementia, which means they are unable to make a decision at that time.

Sexual assault: intentional touching of another person of a sexual nature where the other person does not consent to the touching and the individual does not reasonably believe that they consent.

Sexual assault referral centres: offer medical, practical and emotional support to anyone who has been sexually assaulted or raped. They have specially trained doctors and counsellors to care for and support people.

Sexual consent: where an individual has the freedom and capacity to agree to sexual activity with other people. It is important to note that individuals with mental health conditions may appear to consent to activity, but may lack capacity due to their mental health condition. Some of the incidents in this report may be consensual sexual activity between two people, but have been included as it was not possible to determine whether the people concerned had the mental capacity to make the decision to participate in sexual activity.

Sexual disinhibition: is behaviour that can happen because a person is not able to follow social rules about when and where to say or do something. For example, where sexual impulses or needs are expressed in a direct or disinhibited way, such as in inappropriate situations.

Sexual harassment: any unwelcome or unwanted sexual behaviour that makes the individual feel offended, humiliated or intimidated. This includes unwelcome sexual advances, unwelcome requests for sexual favours and other unwelcome/inappropriate conduct (including staring, leering, and suggestive comments/jokes).

Sexual incidents: for the purposes of this report, this includes any behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable or afraid (see note about 'Sexual consent' above). This includes assault and harassment as described above. It also extends to being spoken to using sexualised language or observing other people behaving in a sexually disinhibited manner, including nakedness and exposure or self-stimulation which may have occurred in a private bedroom or bathroom.

Sexuality: the definition of sexuality for the purposes of this report is deliberately broad. It encompasses a person's gender identity, sexual orientation, and sexual desires and experiences, including relationships.

Sexual safety: in this report, this is defined as feeling safe from any unwanted behaviour of a sexual nature, as defined in 'Sexual incidents' (above).

Sexuality needs: people's needs to express their sexuality, including sexual orientation and gender identity, and to develop and maintain relationships.

Shared Lives: These schemes support adults with a learning disability, mental health problems or other needs that make it harder for them to live on their own. The schemes match someone who needs care with an approved carer. The carer shares their family and community life, and gives care and support to the person with care needs.

Stakeholder: any person, group of people or organisation who has a significant interest in services provided, or can affect or will be affected by any planned changes or project.

Trauma-informed approach to care: links trauma and mental health by recognising its effects and human response. It emphasises the need for physical, psychological and emotional safety and helps survivors to recover, heal and rebuild a sense of control and empowerment.

Links to useful information

[Action on Elder Abuse](#) provides a confidential helpline to provide advice and support to victims and witnesses of abuse

Alzheimer's Society: [Lift the Lid – helping care home staff address taboos](#). Workshop in a box to help care home staff address sex and intimacy issues for people living with dementia

Care Quality Commission, [Relationships and sexuality in adult social care services](#), 2019

Equality and Human Rights Commission, [Hidden in plain sight: inquiry into disability-related harassment](#), 2011

Hestia, [Healthy Relationship Toolkit](#) aims to encourage all individuals, regardless of age, gender or background, to start a conversation around healthy relationships

The International Longevity Centre – UK, [A guide to dementia, sexuality, intimacy and sexual behaviour in care homes](#), 2011

Local Government Association, [Making Safeguarding Personal](#)

Majeed-Ariss R, Rodriguez PM, White C, [‘The disproportionately high prevalence of learning disabilities amongst adults attending Saint Marys Sexual Assault Referral Centre’](#), J Appl Res Intellect Disabil, 2020

NHS England, [Ask Listen Do](#) – supports organisations to learn from and improve the experiences of people with a learning disability, autism or both, their families and carers when giving feedback, raising a concern or making a complaint.

NHS England, [Strategic direction for sexual assault and abuse services – Lifelong care for victims and survivors: 2018 – 2023](#), 2018

Royal College of Nursing, [Older people in care homes: sex, sexuality and intimate relationships – An RCN discussion and guidance document for the nursing workforce](#), 2018

Skills for Care, [Supporting personal relationships – Supporting people who need care and support to have meaningful relationships](#), 2017

Supported Loving [website](#) contains the [Supported Loving toolkit](#), a series of guides to help support people with learning disabilities with issues around sex and relationships

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⁸ Office for National Statistics, [Sexual offences in England and Wales: year ending March 2017](#), 2018

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